The Pediatric Center

Patient Health History Form

Patients Name: _______________________ Date of Birth: ___________________ Today's Date: _____________________________

Name of person completing this form: ______________________________ Relationship to patient: ___________________________

Name of child's previous pediatrician: ____

Delivery and Birth History ☐ Unknown Was your child adopted? Y / N Date of Adoption: _________________________

Place of birth: Name of Hospital/Home ____________________________________City and State: ____________________________

Type of delivery: ____ Vaginal If vaginal breech/feet first? Y / N ____ Caesarean If Caesarean was it planned?: Y / N

If known, how old was the birth mother at time of delivery? __________________ Was the child premature? Y / N days:____ weeks:_____

Child's birth weight: _____________ birth length: ______________ head circumference: ___________

Were there any significant medical problems during your pregnancy? Y / N

Were there any significant complications during labor or the baby's newborn period? Y / N

If yes, to any of the above, please explain: ____

____

Growth and Development

Have you or your prior pediatrician ever had any concerns about your child's growth or development? Y / N
(speech/language, social skills, motor skills, etc)

Please provide your child's age when they first:

Sat up without help: _____ Crawled: _____ Walked without help: ______ Spoke his/her first words: _____ Slept through the night: _______

Girls only: Age at first period: _______

Please indicate any developmental concerns or issues you would like to speak to the provider about: ___________________________________

____

____

Child's Medical History

Please indicate with a "Y" if your child has had any of the following conditions:

Been hospitalized overnight		Pneumonia		Eating Disorder/Anorexia or Bulimia	
Asthma/wheezing		Seizure/Epilepsy		Seasonal Allergies	
Used a nebulizer		Liver Disease/hepatitis		Learning Delay	
Surgery		Kidney Disease		Learning Disability	
Broken bones		Bladder infection		ADD	
Frequent or severe sprains		Sexual Transmitted Disease		Lead Poisoning	
Mental or behavior challenges		Skin problems		Obesity/overweight	
Seen in the Emergency Room		Hearing problems		Emotional/Behavioral Challenges	

If yes, to any of above, please describe on next page.

Child's Medical History (continued)

Please describe: ____

____

____

Medications and Allergies

Please list current medications, vitamins, and supplements, even those used intermittently: ______________________

____

____

Please list allergies or reactions to medications, vaccines or foods:

Allergy Reaction

____________ ______________________

____________ ______________________

____________ ______________________

____________ ______________________

Social History

Please list all those living in the child's household:

Name Age Relationship

____

____

____

____

____

Does your child attend school: Y / N Homeschool: Y / N Daycare: Y / N Have a FT Nanny: Y / N

Does your child attend aftercare: Y / N Does your child attend summer camp: Y / N

Do you have pets in the home: Y / N

If yes, type and number of pets:____

Parents working outside of the home: Y / N ______________________

What language(s) are spoken at home: ______________________

Approximately how many hours a day does your child spend in front of a screen: ______________________

Does your child exercise/play sports: Y / N If yes, when, where and how long: ______________________

____

____

Has your child or anyone in your household traveled internationally in the past 5 years? Y/N If yes, who/m and to where:

____

Please see Family Health History on next page

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Family History

Please indicate with a "X" family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Alcoholism												
Anemia												
Asthma/Wheezing												
Cystic Fibrosis												
TB/Lung Disease												
Autism												
Autoimmune Disorder												
Birth Defect/Congenital Anomaly												
Bleeding Problem												
Blood Disorder												
Sickle Cell												
Anemia												
Thalassemia												
Depression												
Diabetes												
Eczema (Atopic Dermatitis)												
Food Allergy												
Genetic Disorder												
Hearing Disorder												
Heart Disease												
Sudden Cardiac Death												
Heart Attack												
High Blood Pressure												
High Cholesterol												
Immune Disorder												
Inflammatory Bowel Disease												
Kidney Disease												
Mental Retardation												
Learning Disability												
Migraine Headaches												
Psychiatric/Mental Illness												
Scoliosis												
Seizure Disorder												
Stroke												
Substance Abuse												
Thyroid Disorder												
Tobacco Use												
Tuberculosis												
Death before age 56												

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